MONTANA
Department of Public Health & Human Services

June 6, 2003
Montana Medicaid Notice
Hearing Aid and Audiology Providers

Heading Aid Services Documentation Changes

Effective July 1, 2003, new documentation will be required for requesting hearing aid(s).

Hearing Aid Dispensers will be required to submit the revised Prior Authorization Request Form for all hearing aid requests. This revised form must be completed and signed by the provider who will dispense the hearing aid(s) if approved by the Department or its designee.

As an additional required attachment, Hearing Aid Dispensers must include the new Certificate of Medical Necessity (CMN) with the prior authorization request form. The CMN must be completed and signed by the Audiologist who performed the required audiological evaluations of the patient.

All hearing aid requests received on or after July 1, 2003, must consist of the following:

- Revised prior authorization request form
- Physician's referral for audiological evaluations
- Audiology report
- Audiogram
- New hearing aid CMN

Incomplete requests will be returned to the submitting Hearing Aid Dispenser for completion and reprocessing.

The new/revised forms are attached to this notice and available for downloading from the Provider Information website at **http://www.mtmedicaid.org**

Contact Information

If you need additional information or have claims questions, contact Provider Relations:

Provider Relations in Helena and out-of-state: (406) 442-1837
In-state toll-free: 1-800-624-3958

MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY
Hearing Aid Services (Rev., July 2003)

HEARING AID EVALUATION

Patient Name, Address, Telephone Number, Date of Birth Medicaid Number	**Audiologist Name**, Address, Telephone Number
Referring Physician Name, Address, Telephone Number	**Date of Evaluation/Referral** _____

Diagnosis

Date of Audiological Examination

Audiometric Test Results:

	Right Ear	Left Ear
500Hz	_____	_____
1000Hz	_____	_____
2000Hz	_____	_____
3000Hz	_____	_____
Total Average	_____	_____
PB Max Level	_____	_____

Y / N The two-frequency average at 1 KHZ and 2 KHZ is greater than 40 decibels in both ears.

Y / N The two-frequency average at 1 KHZ and 2 KHZ is less than 90 decibels in both ears.

Y / N The two-frequency average at 1 KHZ and 2 KHZ has an interaural difference of less than 15 decibels.

Y / N Word recognition or speech discrimination score is not greater than 20%.

Comments/Recommendations

I certify that I am the audiologist completing the audiological evaluation for the patient identified in this form. I certify that the information contained in this document and its attachments are true, accurate, complete and supported by clinical information in the patients record. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Audiologist Signature _____ **Date** _____/_____/_____ *(Stamps Are Not Acceptable)*

Attachments: This form must be accompanied by copies of supporting documentation to include, but not limited to the physician=s referral for hearing aid services, diagnostic and evaluation reports. Attachments are necessary for dispenser to request approval of the hearing aid(s) prior to the actual dispensing of the aid(s).

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MEDICAID

MONTANA MEDICAID PRIOR AUTHORIZATION REQUEST FORM
Hearing Aid Services (Rev., July 2003)

HEARING AID

Patient Name, Address, Telephone Number, Date of Birth Medicaid Number	**Hearing Aid Dispenser Name**, Address, Telephone Number Medicaid Provider Number
Referring Physician Name, Address, Telephone Number	**Audiologist Name**, Address, Telephone Number

1. Does the patient presently have hearing aid(s)? **Y / N**
   If yes, please complete the following:

Make_____, Model_____, Date Acquired_____

Replacement Remarks:

2. Does the patients conditions meet the criteria specified in the Montana Medicaid Hearing Aid Services Provider Manual? **Y / N**

3. Has the patient received a trial use of this item? **Y / N**
   If yes, for how long: _____

4. Does the patient have the ability to operate/use this requested item as intended by the items manufacture? **Y / N**

SPECIFICATION LIST

NOTE: ALL BILLABLE ITEMS/SERVICES THAT MAKE UP THIS REQUEST MUST BE LISTED INDIVIDUALLY BELOW. If additional space is needed, a continued sheet can be attached to this document as long as the pertinent patient and supplier information is included at the top of the attachment.

HCPCS	Description	Manufacture	Model/Product #	*Departmental Use Only*

I certify that the information contained in this document and its attachments/supporting documents are true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability. I further understand my responsibilities, as a condition of participation in the Montana Medicaid Program , to comply with all applicable state and federal statutes, rules, regulations and policies.

Dispenser Signature: _____ **DATE** _____/_____/_____ *(Stamps Are Not Acceptable)*

Attachments: This form must be accompanied by copies of supporting documentation to justify the medical need of the requested items. Supporting documentation includes, but is not limited the physicians referral for audiological evaluations, audiology report, audiogram and CMN.

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